

Mental Health Care Provider Survey

The Michigan Department of Community Health is attempting to analyze the availability of mental health care in your area for the purposes of Health Professional Shortage Area (HPSA) designation review. Areas qualifying for HPSA designation have Federal and State resources made available to them to assist in maintaining and expanding the area's primary care infrastructure. To collect the data required for this review, we need your assistance in filling out the survey below (2 pages) for each Core Mental Healthcare Provider at your office (for shortage designation purposes core mental healthcare providers include psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists). Thank you for your participation in this important process.

Provider Information		
Provider's Name:		
Phone Number:	License Number (optional):	
County of practice location:		

1. Type of Provider:	2. Degree or Certificate of provider:
<input type="checkbox"/> Psychiatrist	<input type="checkbox"/> M.D. <input type="checkbox"/> D.O.
<input type="checkbox"/> Clinical Psychologist	<input type="checkbox"/> Ph.D. <input type="checkbox"/> Limited License (Specify):
<input type="checkbox"/> Clinical Social Worker	<input type="checkbox"/> Certified CSW <input type="checkbox"/> MSW
<input type="checkbox"/> Psychiatric Nurse Specialist	<input type="checkbox"/> Certified <input type="checkbox"/> Masters in Nursing
<input type="checkbox"/> Marriage or Family Therapist	<input type="checkbox"/> Masters <input type="checkbox"/> Doctoral
<input type="checkbox"/> Other (Specify):	<input type="checkbox"/> Other (Specify):

3. At what addresses does the provider practice?
Facility Name:
Address 1:
City/Zip:
4. How many hours per week does the provider spend in outpatient care activities here?

5. Does the provider practice at other locations? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what are those locations, and how many hours does the provider spend in outpatient care activities at each?
Facility Name:
Address 2:
City/Zip:
Hours/Week:
Facility Name:
Address 3:
City/Zip:
Hours/Week:

6. Does this office operate under the area's Community Mental Health Agency?
<input type="checkbox"/> Yes <input type="checkbox"/> No

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7. It is well known that payment for patients who have Medicaid coverage can create financial hardships for mental healthcare providers. Does the provider accept Medicaid Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, about what percentage of the provider's practice is made up of patients who have Medicaid coverage: %

8. Is the office able to discount charges for low-income patients without Medicaid or other insurance coverage through a sliding fee scale? <input type="checkbox"/> Yes <input type="checkbox"/> No (Defined as general office policy in which fees are dependent on the income of the patient)
If yes, what percentage of the provider's practice is made up of low-income patients lacking insurance, who use a sliding fee scale? %

9. Does the provider have any additional time consuming responsibilities? <input type="checkbox"/> Administrative Responsibilities <input type="checkbox"/> Research <input type="checkbox"/> Teaching <input type="checkbox"/> Semi-Retired <input type="checkbox"/> Other (Specify):
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10. Is the provider currently accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No

11. Are there any other core mental healthcare providers in this office? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please fill out a survey for each additional core mental healthcare provider.

After completing the survey, please return to the Michigan Department of Community Health at:

**Shortage Designation Analyst
 Michigan Department of Community Health
 Health Planning and Access to Care Section
 Capitol View Building, 7th Floor
 201 Townsend
 Lansing, Michigan 48913**

FAX: (517) 241-1200